BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

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In The Matter of Charges and Complaint Against BRIAN DOUGLAS CRONK, P.A.-C., Respondent.	**Case No. 10-18588-1**

FILED
APR 20 2010
NEVADA STATE BOARD OF MEDICAL EXAMINERS

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
1105 Terminal Way #301
Reno, Nevada 89502
(775) 688-2559

COMPLAINT

The Investigative Committee of the Board of Medical Examiners of the state of Nevada, composed of Charles N. Held, M.D., Chairman, Theodore B. Berndt, M.D. Member, and Valerie Clark, Member, by and through Bradley O. Van Ry, Deputy General Counsel for the Nevada State Board of Medical Examiners, having a reasonable basis to believe that Brian Douglas Cronk, P.A.-C, hereinafter referred to as "Respondent," has violated the provisions of NRS Chapter 630, hereby issues its formal Complaint, stating the Investigative Committee's charges and allegations, as follows:

1. Respondent's license is currently in suspended for non-payment status (License No. PA643), but was licensed in active status at all times addressed herein and was so licensed by the Nevada State Board of Medical Examiners on March 20, 2000 pursuant to Chapter 630 of the Nevada Revised Statutes.

2. Patient A was a fifty-one year old male at the time of the matters in question. His true identity is not disclosed to protect his privacy, but his identity is disclosed in the Patient Designation served on Respondent along with a copy of this Complaint.

3. On December 7, 2004, Patient A was first seen at the Gastroenterology Center of Nevada (the "Center"). He was previously diagnosed with Hepatitis C by his primary care

physician at Southwest Medical Associates. Patient A was first worked up by another P.A.-C at the Center who performed a thorough history and physical. This first P.A.-C recommended a liver biopsy among other things.

4. Previous diagnostic studies performed on Patient A in November, 2004, and prior to being seen by any P.A.-C at the Center, identified a mass on Patient A's liver. The mass was not consistent with carcinoma. The size of the mass varied from 5 cm to 7 cm depending on the diagnostic tool, i.e. CT scan or ultrasound.

5. Patient A presented to Respondent on January 5, 2005. Respondent confirmed the previous diagnoses of Hepatitis C and cirrhosis and recommended a liver biopsy among other things.

6. The liver biopsy was performed on January 13, 2005. The findings were consistent with chronic Hepatitis C of moderate activity (grade 3 of 4) and cirrhosis (stage 4 of 4). No carcinoma was identified at this time.

7. At a follow-up appointment on January 24, 2005, Patient A complained of intermittent sharp right upper quadrant pain. Respondent, therefore, planned a follow-up ultrasound for the future, but Respondent never followed up to ensure that it took place.

8. From March 2005 to May 2006, Patient A saw Respondent eleven times, generally monthly. No follow-up ultrasound or CT scan was ever performed on Patient A, or ordered, by Respondent.

9. Patient A subsequently underwent a 48-week combination treatment for Hepatitis C ending in May of 2006. On May 8, 2006, Respondent referred Patient A to a liver specialist for recommendations on further treatment. On or about June 1, 2006, Patient A presented to Cal-Pacific Medical Center.

10. A liver ultrasound was then performed on June 16, 2006 that showed the original identified mass had grown to 10 cm and appeared to be carcinoma. A CT scan performed on July 5, 2006 showed that the mass was most likely hepatocellular carcinoma. A biopsy later performed on July 26, 2006 identified well differentiated hepatocellular carcinoma.

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11. Patient A was unsuccessfully treated for the carcinoma and died on October 12, 2007.

12. Respondent failed to use the reasonable care, skill, or knowledge ordinarily used under the same or similar circumstances when he failed and omitted to require a follow-up CT scan and or ultrasound on Patient A's liver after January 13, 2005. Respondent also failed to use the reasonable care, skill, or knowledge ordinarily used under the same or similar circumstances by, among other things, failing to recognize the inherent risk of carcinoma in patients with Hepatitis C and Cirrhosis, failing to exercise due diligence in the follow-up of the previous abnormal radiology exam and failing to require follow-up diagnostic studies as recommended by the radiologist.

Count I

13. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

14. Nevada Administrative Code Section 630.380(1)(f) provides that disciplinary action may be taken against a physician assistant if they are found to have committed malpractice.

15. Nevada Administrative Code Section 630.040 defines malpractice as the failure, in treating a patient, to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances.

16. By reason of the foregoing, Respondent is subject to discipline by the Nevada State Board of Medical Examiners as provided in Section 630.410 of the Nevada Administrative Code.

WHEREFORE, the Investigative Committee prays:

1. That the Nevada State Board of Medical Examiners fix a time and place for a formal hearing;

2. That the Nevada State Board of Medical Examiners give Respondent notice of the charges herein against him, the time and place set for the hearing, and the possible sanctions against him;

3. That the Nevada State Board of Medical Examiners determine what sanctions it wishes to impose for the violation or violations committed by Respondent;

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4. That the Nevada State Board of Medical Examiners make, issue and serve on Respondent its findings of facts, conclusions of law and order, in writing, that include the sanctions imposed; and

5. That the Nevada State Board of Medical Examiners take such other and further action as may be just and proper in these premises.

DATED this 21st day of April, 2010.

INVESTIGATIVE COMMITTEE OF
THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____
Bradley O. Van Ry
Deputy General Counsel for the Investigative Committee of the Nevada State Board of Medical Examiners

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VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF DOUGLAS)

Charles N. Held, M.D., hereby deposes and states under penalty of perjury under the laws of the state of Nevada that he is the Chairman of the Investigative Committee of the Nevada State Board of Medical Examiners that authorized the foregoing Complaint against the Respondent herein; that he has read the foregoing Complaint; and that based upon information discovered during the course of the investigation into a complaint against Respondent, that he believes the allegations and charges in the foregoing Complaint against Respondent are true, accurate, and correct.

DATED this 20th day of April, 2010.

CHARLES N. HELD, M.D.

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CERTIFICATE OF MAILING

I hereby certify that I am employed by Nevada State Board of Medical Examiners and that on 20th day of April 2010, I served a file copy of the COMPLAINT, PATIENT DESIGNATION, ORIGINAL SETTLEMENT, WAIVER & CONSENT AGREEMENT & Fingerprint Processing Information by mailing via USPS certified return receipt mail to the following:

Cheryl Horner, Esq.
Horner Law Firm
241 W. Charleston Blvd., Ste. 155
Las Vegas, NV 89102

Dated this 20th day of April 2010.

Angelia L. Donohoe
Legal Assistant

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